This Amended Findings and Decision supercedes all previous decisions rendered in this matter.

The Medical Review Division's Findings and Decision of June 20, 2003, was issued in error and subsequently withdrawn by the Medical Review Division. The Original Findings and Decision, Appeal Letter and Withdrawal Notice are reflected in Exhibit 1.

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 11-19-02.

## I. DISPUTE

Whether there should be additional reimbursement for date of service 4-17-02 for Durable Medical Equipment, HCPCS codes E0753 (Implantable Neurostimulator Electrodes Per group of four leads) and E0751 (Implantable Pulse Generator and Programmer).

## II. FINDINGS

a. Based on Commission Rule 133.307(d)(1-2), the only date of service eligible for review is 4-17-02.

b. The Provider billed the insurance carrier $28,150.00.

c The insurance carrier paid a total reimbursement of $14,818.03.

d The insurance carrier based their reimbursement based upon, "M – Payment recommendation based on fair and reasonable which FORTE has defined as the Texas 2002 Medicare DME Fee Schedule plus 20%; and M – Payment recommendation based on fair and reasonable which FORTE has defined as the Texas 2001 Medicare DME Fee Schedule plus 20%."

e Per the TWCC-60 the total amount in dispute is $13,331.97.

f. The requestor wrote, "We do not understand how the allowances can be determined by a fee schedule for codes that are no longer current in 2002 with Medicare. We are required to bill the appropriate codes accepted by Texas Workers Compensation Commission, however, these codes, E0753 and E0751 are no longer the appropriate codes recognized by Medicare. Furthermore, if ___ used the allowable fees for the correct 2002 Medicare Codes (E0752, E0757 and E0758) and added 20% the allowable fee would be much greater than the reimbursement allowed. It is our experience with Workers Compensation claims in the state of Texas that reimbursement for these codes is allowed either at 85% of the billed amount OR a percentage actual invoice cost (usually 20%).

We submitted the actual cost invoice with our previous request indicating that the allowed reimbursement was significantly below the actual cost of the equipment."

g. The respondent wrote, "Per TWCC Rule 133.304(n), for bills with a date of service after 7/15/00, a request for reconsideration may only be submitted once after a carrier has taken final action on a complete medical bill and provided an explanation of benefits."

## III. RATIONALE

a. Based upon the HCFA-1500, the requestor billed $9500.00 for 4 units of E0753 (4/$9500.00 = $2375.00 ea); and $18,650.00 for E0751.

b. Per Durable Medical Equipment Ground Rule (IX)(C), "The provider shall use the HCFA-1500 Form for billing. Invoices should be billed at the provider's usual and customary rate. Reimbursement shall be an amount pre-negotiated between the provider and carrier or if there is no pre-negotiated amount, the fair and reasonable rate. A fair and reasonable reimbursement shall be the same as the fees set for the "D" codes in the 1991 Medical Fee Guideline."

c. A review of the 1991 Medical Fee Guideline does not contain Implantable Neurostimulator Electrodes Per group of four leads and Implantable Pulse Generator and Programmer. The documentation did not contain a pre-negotiated amount between the provider and carrier; therefore, the appropriate reimbursement is a fair and reasonable rate.

d. Section 413.011(b) states, "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

e. The requestor wrote in their letter dated 9-24-02 that, "reimbursement for these codes is allowed either at 85% of the billed amount OR a percentage above actual invoice cost (usually 20%)." 85% of $28,150.00 = $23,927.50. The invoice indicates that the sales amount was $17,740.00. 20% of $17,740.00 = $3548.00. $17,740.00 + $3548.00 = $21,288.00.

f. The requestor provided redacted EOBs that supported above position regarding reimbursement methodology. Therefore, the Medical Review Division considers fair and reasonable reimbursement the lesser amount of $21,288.00.

g. The difference between fair and reasonable reimbursement of $21,288.00 and amount paid of $14,818.03 = $6469.97.

This Amended Findings and Decision is hereby issued this 09th day of September 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division

## IV. ORDER

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor **is** entitled to additional reimbursement for HCPCS code(s) E0753 and E0751 in the amount of **$ 6469.97.** Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Division hereby ORDERS the Respondent to remit **$6469.97** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

This Order is hereby issued this 09th day of September 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division